HCFA MEDICARE • MEDICAID Health Care Financing Administration

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HEALTH watch

HCFA Restructures to Serve Customers Better

As part of HCFA's agency-wide restructuring, expected to be implemented by mid-1997, an outline of the agency's new organizational structure and office functions was recently announced in the *Federal Register*. This new structure, which focuses on HCFA as a "beneficiary-centered purchaser" of health care services, is built around three large units, called "centers." There will be one center for each of HCFA's primary audiences or customer groups — beneficiaries, health plans and providers, and states.

The three centers will provide "one-stop shopping" for individuals and organizations interacting with HCFA. Other units with specialized expertise such as clinical, financial, information systems, communication and legislation will support all three centers. A new Office of Strategic Planning will bring together research, actuarial analysis, and environmental scanning in order to provide analytical support to HCFA's senior leadership on long-term strategic direction for the agency and its programs. In addition, for the first time, four field executives (Consortium Administrators) will be included as part of the agency's top deliberative body, bringing local perspectives to compelling issues.

Since December, teams of HCFA staff and managers from headquarters and ten regional offices have been working out details of the restructuring. Specifically, these "transition teams" have developed organizational charts for units within each center and office, written statements describing each unit's functions and linkages to other parts of the agency, and evaluated which functions are best performed in headquarters and which would benefit from the "local presence" afforded by the regional and field offices.

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Discharge Planning Seminar Is Held in Cambridge

Because of concerns about the coordination of care when patients move from hospitals to outpatient environments, HCFA recently convened a regional discharge planning conference in Cambridge, Massachusetts. Attendees at the conference — hospital discharge planners, post-acute care facility staff, home health agencies, state officials, staff from congressional offices, advocates, and managed care organization staff — discussed current problems relating to discharge planning and shared approaches to improving the quality of care given to patients.

Mary Kay Browne, Diane Paulson and Sandra Lowery listen to Anne Hargreaves make a point for beneficary needs and concerns about discharge planning.

The conference's keynote speaker, Thomas Delbanco, M.D., Chief, Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, urged attendees to promote the involvement of patients and their families in making discharge planning decisions. Delbanco described seven areas that most affect patients' health care experiences and their relationship with their providers:

- ❒ Respecting individuality.
- ❒ Coordinating care between hospitals, nursing homes, patients' homes, etc.,
- ❒ Providing information and education regarding patients' care,
- ❒ Promoting physical comfort,
- ❒ Providing emotional support and alleviating fear and anxiety,
- ❒ Involving family and friends in health care needs,
- ❒ Preparing for hospital discharge.

A panel of beneficiary representatives echoed Delbanco's concerns that providers of care work with patients and their families to ensure accountability and coordinated care. In addition to the beneficiary panel, other panels discussed challenges and new approaches to discharge planning, the role of regulatory/accrediting agencies, and federal initiatives aimed at improving the quality of care received by Medicare beneficiaries.◆

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration to provide timely information on significant program issues and activities to its external customers.

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Publicaciones sobre Medicare

HCFA recently posted several publications that have been translated into Spanish on its Web site. Those who would enjoy (or benefit) from reading these Medicare documents should browse this address (URL): ***http://www.hcfa.gov/medicare/spmcrpub.htm***. Spanish-translated Medicare documents include the *1996 Guide to Health Insurance for People with Medicare, Guide to Choosing a Nursing Home,* and brochures on home health, hospice, kidney disease, managed care, advance directives and the QMB and SLMB programs. Clicking a title underlined in blue will link the user to the document of choice.◆

Message from the Administrator

BRUCE C. VLADECK

OUR STRATEGY for reforming and modernizing Medicare is multifaceted, as it must be for so large and complex a program. We are pursuing expansions of beneficiary choice, payment reforms, quality initiatives, beneficiary service improvements, and technological improvements — all with the overriding goal of making the program beneficiary centered, by improving quality and effectiveness for the elderly and disabled.

One aspect of our strategy represents a real change in perspective. For almost three decades, as the population aged and experienced more chronic illness, Medicare's managers clung to the proposition that Medicare had no role to play in the long-term care system. That is palpably no longer the case.

This year, Medicare will spend more than $30 billion on post-acute services. But, as this money flows outward, we have serious concerns about the ability of those dollars to effectively and appropriately meet the needs of our beneficiaries. It is past time for Medicare to replace its default long-term care policy with an explicit long-term care policy.

Over the past few years, we have been creating the tools needed to develop this system. Our goal is to create an integrated, beneficiary-centered system of long-term care under Medicare and Medicaid that will meet the needs of those with chronic illnesses and disabilities. This system must be able to promote quality care, access, and continuity for beneficiaries and it must be able to control costs in order to safeguard the Medicare Hospital Trust Fund and protect state budgets.

This system will be driven by an assessment of the patient's characteristics and needs which is usable across different settings and provider types. Payment, care planning, quality assurance, and operational monitoring will all be driven by this professional assessment of a beneficiary's needs.

We will build this system by combining the assessment and tracking tools we currently use to create a single, unified instrument which can be employed from setting to setting. Providers in different settings will have more abundant and more consistent information about a beneficiary's previous medical and health history and present service needs.

These improvements will then give us the opportunity early in the next decade to really begin to rationalize the financing of long-term care using prospective payment techniques and other payment innovations.

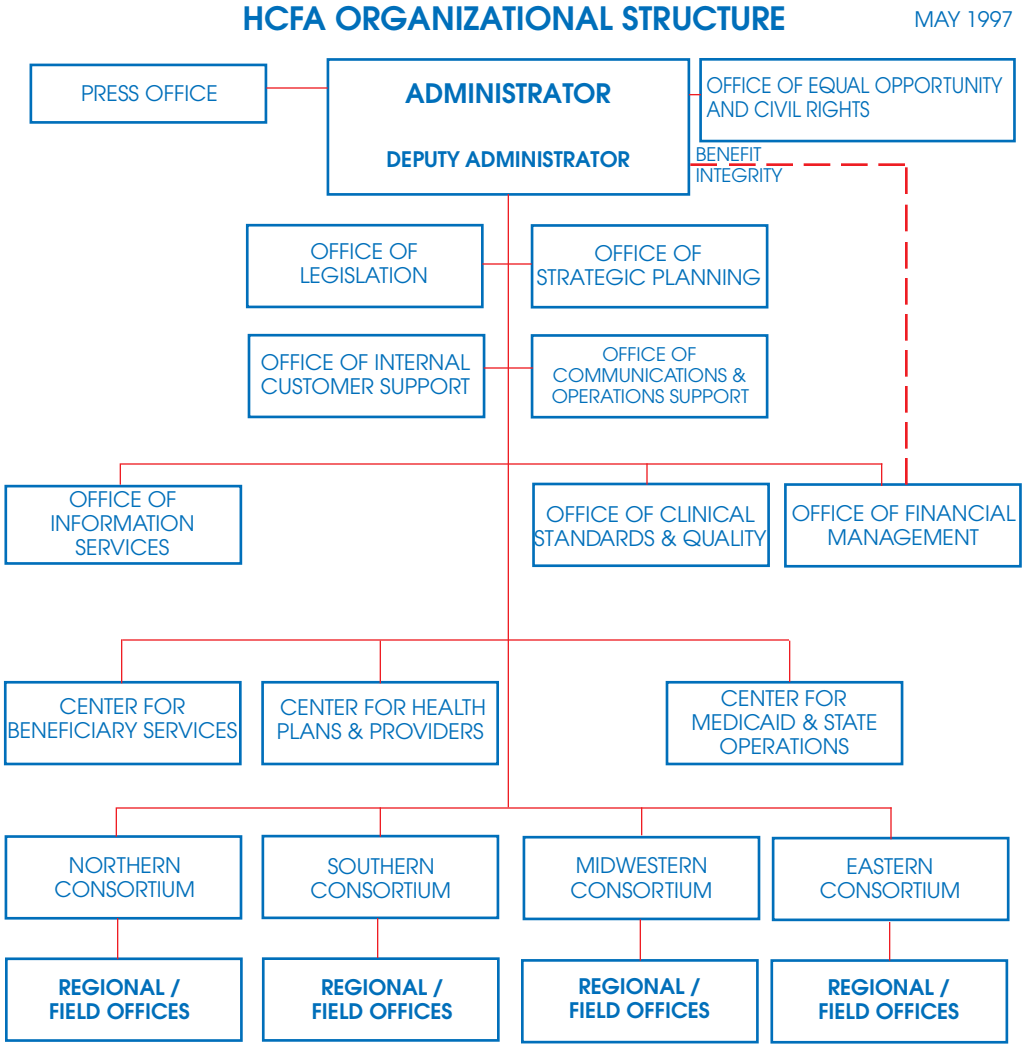
As we work toward this goal of unified care management, we are working in the shorter term to assert greater control of the home health and skilled nursing facility benefits through a variety of proposals ranging from implementing prospective payment to restoring the original division of the home health benefit between post-acute or Part A and chronic, community-based, or Part B of the Medicare program.

HCFA Restructures

[Continued from page 1]

All of these organizational and staffing decisions have been made while keeping in mind HCFA's goal to become a beneficiary-centered purchaser of health care services. This new focus, which was determined after broad consultation within and outside government, means HCFA (in partnership with the states) will actively use purchasing strategies, including market presence, to obtain high-quality health care for beneficiaries at an affordable price. This new approach includes providing beneficiaries with ready access to information about program benefits, health plan choices, treatment options, appeals rights, and choosing a provider of care. Thus, for HCFA, part of becoming a more effective purchaser of care will be assisting beneficiaries and their families to become better-informed purchasers of care.

Administrator Bruce Vladeck is confident that the new HCFA will be more focused on beneficiaries and their needs, more responsive to a rapidly changing environment, and more effective at encouraging improvements to the quality of care while holding the line on the cost of services. While the transformation to beneficiary-centered purchaser will take years, HCFA's new structure will create a strong framework to support the agency's evolving mission.



Center and Office Functions

Center for Beneficiary Services: Serves as the focal point for all of HCFA's interactions with beneficiaries, their families, care givers, and other representatives. Activities will include primary responsibility for all beneficiary contacts and materials, conducting beneficiary needs and satisfaction assessments, providing necessary information about beneficiaries and feedback from beneficiaries to all HCFA components, and administering the Information, Counseling, and Assistance grants. The center has policy and operational responsibility for Medicare enrollment and eligibility activities within the agency.

Center for Health Plans and Providers: Responsible for purchasing health care under the Medicare program. It will serve as the focal point for all programmatic policy and operations issues related to the health care plan and provider communities, including both managed care and fee-for-service. This center has policy responsibility for defining the Medicare benefit and establishing the prices to be paid under Medicare for all services.

Center for Medicaid and State Operations: Serves as the focal point for all of HCFA's interactions with states, local governments (including the Territories), and American Indian and Alaskan Native tribes. This center will house all Medicaid program policy and operations activities including Medicaid 1115 waiver projects and 1915(b) waivers. It also will include survey and certification operations, CLIA activities, and intergovernmental relations activities.

Office of Clinical Standards and Quality: Serves as the focal point for all quality, clinical, and medical science issues and policy for HCFA's programs. This office identifies, develops, and promotes best practices and techniques in quality improvement. It also develops quality standards, conditions of participation, and coverage policy based on clinical considerations.

Office of Strategic Planning: Coordinates HCFA's long-range planning and project efforts, incorporating traditional actuarial and research responsibilities with environmental scanning to help the agency more quickly respond to the changing nature of the health care system.

Office of Information Services: This office, the organizational home of HCFA's Chief Information Officer, is responsible for managing HCFA's information technology assets, enterprise databases and access paths to data, and operational systems.

Office of Financial Management: This office, the organizational home of HCFA's Chief Financial Officer, is responsible for traditional

financial management activities and HCFA program/benefit integrity activities.

Consortia: Regional/field activities are formally grouped into four geographically based consortia. Consortium Administrators sit on the agency's Executive Council, along with directors of centers and major offices. The ten HCFA regional offices will be reconfigured to parallel the three major audience-directed centers. Regional offices/consortia will continue to be heavily involved in issues requiring local presence, such as beneficiary services, state waivers of Medicaid rules, and program integrity.

Office of Communications and Operations Support: Sets standards for agency-wide communications; manages HCFA's regulations, issuances, and correspondence programs; coordinates and monitors short-term agency initiatives.

Office of Internal Customer Support: Serves as HCFA's focal point for human resource and procurement management, logistics, and LAN services.

Office of Legislation: Responsible for current legislative policy and interactions with Congress and congressional staff.

Office of Equal Opportunity and Civil Rights: Provides agency-wide leadership and advice on issues of diversity, civil rights, and promotion of a supportive work environment for agency employees.

Press Office: Serves as HCFA's focal point to the news media.◆

Data Collection Software Released

Available for Quality Improvement Projects

A new software designed to help providers in local quality improvement efforts is now available through HCFA's Web site. MedQuest, a Clinical Data Collection Design System, that can be downloaded at ***http://www.hcfa.gov/medicare/hsqb/medquest/medq1.htm*** enables providers to design sophisticated data entry and collection systems. In addition, MedQuest can also produce a number of word processor-compatible documents and reports, export data, and generate input systems.

MedQuest's "open architecture" system design is based on experience gained in over 500,000 medical abstractions. The open architecture system means that the software can perform a variety of functions including construction, data entry, and exporting abstracted data. It can also be used with third-party tools to perform activities such as data reporting and analysis.

The MedQuest toolset, with its extensive documentation and distribution, offers an example of how HCFA is striving to add value to data requests for itself and other providers. By providing software that allows providers to incorporate HCFA quality improvement projects into broader, local quality improvement efforts, HCFA is helping to build a national quality improvement infrastructure. This infrastructure is in turn expected to help improve the quality of care delivered to Medicare beneficiaries.◆

HCFA Announces Health Care Grants to Doctoral Candidates

Under the HCFA Dissertation Fellowship Grants Program, six doctoral students have been selected to receive up to $20,000 in support of dissertations related to the financing or delivery of health care services. The Dissertation Fellowship Grants Program, in its third year of operation, is designed to stimulate the involvement of new health care service researchers in their studies and aid in career development.

To qualify for the program, a student must be enrolled in an accredited doctoral program in the social, management, or health sciences. The student must be conducting (or intending to conduct) dissertation research on issues related to the delivery or financing of health care services, particularly those affecting the Medicare and Medicaid programs. All applicants must have completed all course work and be sponsored by their university.

1997 Selectees

Sheryl Lynn Stogis, University of Michigan's School of Public Health, Ann Arbor, Mich., will develop a Standardized Donor Ratio (SDR) to help measure the effects of Organ Procurement Organizations (OPOs) in the United States.

Shu-Chuan Jennifer Yeh, Medical College of Virginia, Richmond, Va., will use trend analysis to measure the recent growth of sub-acute care in skilled nursing facilities (SNFs) and develop hypotheses to explain the level of sub-acute care provided by SNFs.

Mei Wang, University of Massachusetts' Program in Public Policy, Boston, Mass., will examine outcomes of patients with acute myocardial infarction in Massachusetts hospitals.

Wenke Hwang, University of Maryland Baltimore County's Policy Science Graduate Program, Baltimore, Md., will study the patterns of End-Stage Renal Disease (ESRD) patients' choices of dialysis facilities and treatments and examine how the type of ownership of ESRD facilities interacts with patients' access by patients' demographic, geographic and medical characteristics.

Adam Atherly, University of Minnesota's Institute for Health Services Research, Minneapolis, Minn., will use information from HCFA's Medicare Current Beneficiary Survey to estimate the effect of supplemental Medicare insurance policies on Medicare costs.

Roy McCandless, University of Texas' School of Public Health, Houston, Tex., will compare different methods for estimating health services use and costs associated with diabetes for Medicare beneficiaries in Texas who are not enrolled in HMOs.◆

For information about the fellowship grants program, please contact HCFA's Office of Research and Demonstrations on 410/786-5181.

Medicare and SSA Trustees Issue Annual Reports

In their annual report to Congress, the Medicare trustees announced that, without corrective legislation, the Hospital Insurance (HI) Trust Fund would be depleted in the Year 2001, due to economic and demographic assumptions. This date is consistent with the one cited in last year's forecast.

To address the short-term financial problems facing the HI Trust Fund, the trustees urged the prompt enactment of legislation to reduce the growth in the HI program cost. They also recommended the establishment of a national advisory group to examine the Medicare program and develop recommendations for effective solutions to the long-term financing problem.

Medicare hospital insurance helps pay for care given by hospitals, skilled nursing facilities, hospices, and home health agencies. The HI Trust Fund (Medicare Part A) is financed mainly by the Medicare portion of the Social Security payroll tax. The Medicare payroll tax rate of 2.9 percent is contributed equally by employers and employees.

The Supplementary Medical Insurance (SMI) Trust Fund (Medicare Part B) helps pay for the services of physicians and other health care professionals, outpatient services, independent laboratory services and durable medical equipment. The SMI program, which the trustees said is expected to remain adequately solvent for the future, is financed mostly by general government revenues and monthly premiums paid by beneficiaries.

In addition to the HI and SMI Trust Fund reports, the Social Security Administration's Board of Trustees announced that the Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds, which support benefit payments to nearly 44 million Americans, are in good financial condition. According to the trustees, those combined trust funds can continue paying benefits for the next 32 years, even without changes in current law.◆

Upcoming Events of June and July

JUNE 4 Administrator Vladeck speaks at the New York University Medical Center in New York City.

JUNE 5 Administrator Vladeck speaks at the PHS/HCFA Primary Care Policy Fellowship Day in Baltimore, Md., on *An overview of the current initiatives, issues and agenda for HCFA, as well as directions for the future.*

JUNE 10 Administrator Vladeck addresses the American Health Care Association in Washington, D.C., on *The Administration's Medicare and Medicaid agenda.*

JUNE 12 Administrator Vladeck speaks at the New York Citizens' Committee on Aging/American Association of Retired Persons (of New York State) New York Statewide Senior Action Council and NYNEX in Manhattan, N.Y., on *An overview of the issues facing Medicare today and the outlook for its future.*

JUNE 17 Administrator Vladeck addresses the Prospective Payment Assessment Commission in Washington, D.C., on *Long-Term Care post-acute care services.*

JUNE 28 Administrator Vladeck speaks at the Medical Administrators Conference in Washington, D.C., on *HCFA programs.*

JULY 11 Administrator Vladeck addresses the Institute of Medicine's National Academy of Sciences in Washington, D.C., on *The future of the clinical research enterprise.*

Payment Date Changed for New Social Security Beneficiaries

In anticipation of tremendous growth in Social Security workloads expected as the baby boom generation gets closer to retirement, the Social Security Administration recently announced that new beneficiaries will be paid on the second, third, or fourth Wednesday of each month rather than the traditional third day of the month (see table).

Persons receiving Supplemental Security Income (SSI) and persons already receiving Social Security on the third of the month are not affected. All SSI beneficiaries and new SSI applicants will remain on the "first day of the month" payment schedule.◆

Birth date between	Benefits paid on
1st-10th	Second Wednesday
11th-20th	Third Wednesday
21st-31st	Fourth Wednesday

New Regulations/Notices

Medicaid Program; New and Pending Demonstration Project Proposals Submitted Pursuant to Section 1115(a) of the Social Security Act: February 1997 (ORD-098-N) — Published 4/17 No Section 1115 proposals for Medicaid demonstration projects were submitted, approved, disapproved, or withdrawn from the Department of Health and Human Services during the month of February 1997. (This notice can be accessed on the Internet at ***http://www.hcfa.gov/ord/ordhp1.html***.)

Medicare and Medicaid Programs; Announcement of Additional Applications from Hospitals Requesting Waivers for Organ Procurement Service Area (BPD-894-NC) — Published 4/21 This notice announces eight additional applications received from hospitals requesting waivers from dealing with their designated organ procurement organizations (OPOs). It supplements *Federal Register* notices of January 19, 1996, May 17, 1996, and November 8, 1996.

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances (BPO-141-N) — Published 4/21 This notice lists HCFA manual instructions, substantive and interpretive regulations, and other *Federal Register* notices published during July - September 1996 that relate to the Medicare and Medicaid programs. It also identifies certain devices with investigational device exemption numbers approved by the Food and Drug Administration that may be potentially covered under Medicare.

Medicare Program; Initiative Involving Facilities That Furnish Hemodialysis Treatments (HSQ-232-N) — Published 4/29 This notice announces HCFA's planned initiative to demonstrate the feasibility of collecting, collating, and analyzing data about the treatment of hemodialysis patients. The collected data will be distributed to participating facilities in a timely manner so that it may be used for quality improvement. This effort is intended to lead to the development of a quality assessment system for hemodialysis facilities that will permit facilities to track, on a routine basis, facility specific health and clinical outcome measures. This initiative will have several phases, the first of which is described in this notice.

Medicare Program; Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans (OMC-025-FC) — Published 4/30 This final rule with comment period establishes a new administrative review requirement for Medicare beneficiaries enrolled in health maintenance organizations (HMOs), competitive medical plans (CMPs), and health care prepayment plans (HCPPs). This rule implements a statutory requirement that specifies the appeal and grievance rights for Medicare enrollees in HMOs and CMPs. It also revises the definition of appealable determinations to clarify that it includes a decision to discontinue services.

Medicare Program; Update of the Reasonable Compensation Equivalent Limits for Services Furnished by Physicians (BPD-816-N) — Published 5/5 This notice sets forth updated Medicare payment limits on the amount of allowable compensation for services furnished by physicians to providers that are not covered by the prospective payment system or per resident payments for graduate medical education.

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